PATIENT INFORMATION

FIRST NAME:_____ MI:____ LAST NAME:_____ DATE:_____
NOMBRE INICIAL APELLIDO FECHA

DATE OF BIRTH:_____ SOC SEC #:_____ SEX: ☐ FEMALE ☐ MALE
FECHA DE NACIMIENTO SEGURO SOCIAL SEXO FEMENINO MASCULINO

ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE:_____
DIRECCION CIUDAD ESTADO CODIGO POSTAL

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____
ELEFONO DE CASA TELEFONO DE TRABAJO TELEFONO CELLULAR

E-MAIL_____
CORREO ELECTRONICO

EMPLOYER:_____ OCCUPATION:_____
EMPLEADOR POSICION

EMERGENCY

CONTACT_____ PHONE:_____ RELATIONSHIP:_____
CONTACTO DE EMERGENCIA TELEFONO PARENTESCO

REFERRING DR./PRIMARY DR:_____ **PHONE:**_____
DOCTOR QUE LO REFIERE/MEDICO DE CABECERA TELEFONO

LANGUAGE PREFERENCE:_____

GUARANTOR & PARTY RESPONSIBLE FOR BILL

FIRST NAME:_____ MI: _____ LAST NAME:_____ RELATIONSHIP:_____
NOMBRE INICIAL APELLIDO PARENTESCO

DATE OF BIRTH:_____ SOC SEC#:_____ SEX: ☐ FEMALE ☐ MALE
FECHA DE NACIMIENTO SEGURO SOCIAL SEXO FEMENINO MASCULINO

ATTORNEY NAME:_____ PHONE NUMBER:_____

INSURANCE INFORMATION

☐ **MEDICARE** ☐ **MEDICAID** ☐ **AUTO** ☐ **WORKERS COMP** ☐ **COMMERCIAL** ☐ **SELF PAY**

PRIMARY INSURANCE:_____
SEGURO PRIMARIO

SECONDARY INSURANCE:_____
SEGURO SECUNDARIO

ATTORNEY NAME:_____

DISCLAIMER AND INFORMED CONSENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
I hereby request and authorize **Physical Therapy Institute and Aquatic Rehab, Inc./ Royal Palm Beach Rehab, Corp. / Action Physical Therapy, LLC.** To perform diagnostic tests and give treatment as deemed necessary. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give consent to that treatment.

PATIENT'S SIGNATURE_____ **DATE**_____
FIRMA DEL PACIENTE FECHA

WITNESSED BY_____ **DATE**_____
ATESTIGUADO POR FECHA

If the patient is a minor, permission is hereby given by me to the doctors of this office and whomever they designate to treat The patient. I am the patients' legal guardian.

GUARDIAN'S SIGNATURE_____ **DATE**_____
FIRMA DEL REPRESENTANTE LEGAL

Patients Name: _____

Patients Height: _____

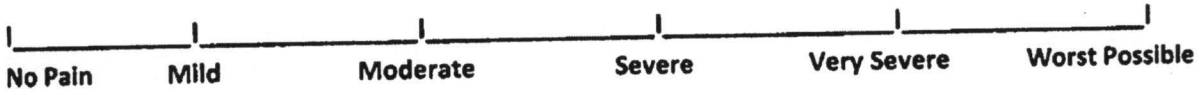
Patients Weight: _____

BMI: _____

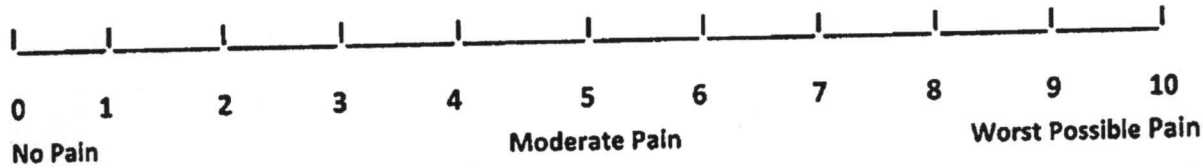
Medication List: **(Please list ALL of the medications you are currently taking)**

Medication Name	Dosage	Frequency	Route (by mouth or injection)	Other

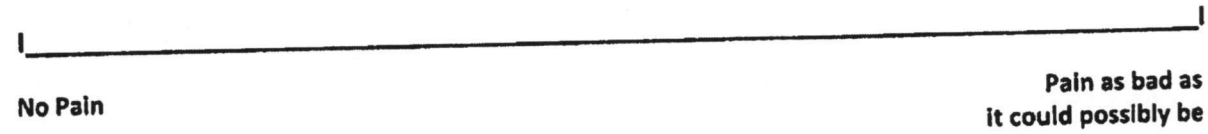
Simple Descriptive Pain Intensity Scale



0-10 Numeric Pain Intensity Scale



Visual Analog Scale (VAS)



Patients Signature: _____

Medical History

PATIENT NAME_____ DATE _____

PAST MEDICAL HISTORY - Have you had any of the following symptoms or conditions:

Allergies	YES	NO	Foot Troubles	YES	NO	Rheumatic Fever	YES	NO
Anemia	YES	NO	Gall Bladder	YES	NO	Rheumatoid Arthritis	YES	NO
Asthma	YES	NO	Pacemaker	YES	NO	Severe Headaches	YES	NO
Broken Bones	YES	NO	Head Injury	YES	NO	Shortness of Breath	YES	NO
Cancer	YES	NO	Heart Trouble	YES	NO	Yellow Jaundice	YES	NO
Diabetes	YES	NO	Hernia	YES	NO	Varicose Veins	YES	NO
Ear Trouble	YES	NO	High Blood Pressure	YES	NO	Tumor	YES	NO
Epilepsy	YES	NO	Kidney Trouble	YES	NO	Tuberculosis	YES	NO
Eye Trouble	YES	NO	Mental or Nervous	YES	NO	Skin Conditions	YES	NO
Fainting Spells	YES	NO	Disorders	YES	NO	HIV	YES	NO

Are you presently under a Doctor's care for any condition? YES NO Please Explain _____

_____

Do you have allergies to any medication? YES NO Please Explain _____

_____

Current Subjective Complaints

Date symptoms started : _____

Please describe your condition and how it happened: _____

_____

What activities if any make your condition better? _____

_____

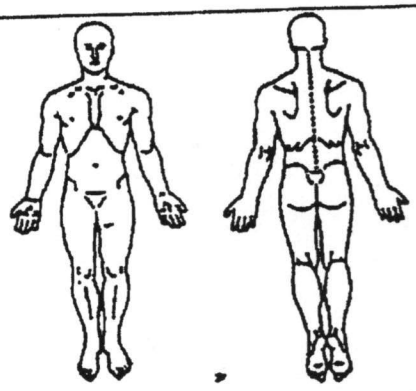
Date of last X-Rays_____ What body part were taken? _____

WOMEN ONLY ARE YOU PREGNANT? YES NO Date of last Menstrual Cycle _____

Please mark the diagram below to point out where your pain is:

HEAD

____ Headaches - How often? _____
____ Light Headed
____ Double Vision
____ Hearing Loss
____ Memory Loss
____ Ringing in Ears
____ Fainting
____ Blurred Vision
____ Loss of Balance
____ Dizziness
____ Sensitive to Light
____ TMJ / Jaw Symptoms



Action Physical Therapy LLC Financial Policy/Assignment of Benefits

Thank you for choosing Action Physical Therapy , LLC as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All copays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, Mastercard, Amex & Discover. There is a $34 return check fee.
- If any portion of your account balance exceeds 60 days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO INDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES.

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Action Physical Therapy, LLC and any of its duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned 's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Action Physical Therapy, LLC, when which checks, drafts or money orders are made payable for services which have been rendered by Action Physical Therapy, LLC, at the request or with the knowledge and approval of the undersigned and/or the make of the check, drafts or money order. Furthermore, the undersigned allows Action Physical Therapy, LLC. Or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Action Physical Therapy, LLC. as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me The patient, to release true copies of the same to Action Physical Therapy, LLC. or any insured providing the coverage to me in connection with the process of any other claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize_____

(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Action Physical Therapy, LLC.
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Action Physical Therapy, LLC. any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Action Physical Therapy, LLC.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____

Signature of Patient (parent/guardian, if minor)_____Date:_____

Patients Name (Please Print):_____

Insurance

We accept all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Action Physical Therapy LLC will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & represent a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Royal Palm Beach Rehab. Corp.-Financial Policy/Assignment of Benefits

Thank you for choosing Royal Palm Beach Rehab. Corp. as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All co-pays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, MasterCard, Amex & Discover. There is a $34 return check fee.
- If any portion of your account balance exceeds 60days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Royal Palm Beach Rehab. Corp. and any of it's duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Royal Palm Beach Rehab. Corp. when which checks, drafts or money orders are made payable for services which have been rendered by Royal Palm Beach Rehab. Corp. at the request or with the knowledge and approval of the undersigned and/or the make of the check, draft or money order. Furthermore, the undersigned allows Royal Palm Beach Rehab. Corp. or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Royal Palm Beach Rehab. Corp. as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me, the patient, to release true copies of the same to Royal Palm Beach Rehab. Corp. or any insured providing the coverage to me in connection with the process of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize_____
(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Royal Palm Beach Rehab. Corp.

Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100 Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Royal Palm Beach Rehab. Corp. any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Royal Palm Beach Rehab. Corp.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____.

Signature of Patient (parent/guardian, if minor) _____Date:_____

Patients Name (Please Print):_____

Insurance

We accept Medicare, all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Royal Palm Beach Rehab. Corp. will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & present a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Physical Therapy Institute and Aquatic Rehab Inc-Financial Policy/Assignment of Benefits

Thank you for choosing Physical Therapy Institute and Aquatic Rehab Inc as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All co-pays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, MasterCard, Amex & Discover. There is a $34 return check fee.
- If any portion of your account balance exceeds 60days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED. INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Physical Therapy Institute and Aquatic Rehab Inc and any of it's duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Physical Therapy Institute and Aquatic Rehab Inc, when which checks, drafts or money orders are made payable for services which have been rendered by Physical Therapy Institute and Aquatic Rehab Inc. at the request or with the knowledge and approval of the undersigned and/or the make of the check, draft or money order. Furthermore, the undersigned allows Physical Therapy Institute and Aquatic Rehab Inc or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Physical Therapy Institute and Aquatic Rehab Inc as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me, the patient, to release true copies of the same to Physical Therapy Institute and Aquatic Rehab Inc or any insured providing the coverage to me in connection with the process of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize_____
(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Physical Therapy Institute and Aquatic Rehab Inc
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Physical Therapy Institute and Aquatic Rehab Inc any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Physical Therapy Institute and Aquatic Rehab Inc.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____.

Signature of Patient (parent/guardian, if minor) _____Date:_____

Patients Name (Please Print):_____

Insurance

We accept Medicare, all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Physical Therapy Institute and Aquatic Rehab Inc will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & present a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Royal Palm Beach Rehab. Corp., Physical Therapy Institute and Aquatic Rehab, and Action Physical Therapy LLC.

Royal Palm Beach

Notice of Privacy Practices

Date: _____

Patient Name:_____

This is to certify that I, _____ have been given, offered or have seen the posted copy of the **Notice of Privacy Practices** (also known as HIPAA).

_____ _____

Signature of Patient/Guardian Date

_____ _____

Signature of Clinic representative Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Form, but was unable to do so as documented below:

Date:	Initials:	Reason:

Physic... Therapy Institute and Aquatic Rehab

4972 Le Chalet Blvd, Suite 100
Boynton Beach, Fl 33436
Ph-561-733-5590
Fax-561-740-0714

106 Ponce De Leon St
Royal Palm Beach, Fl 33411
Ph-561-791-9090
Fax-561-791-9072

2632 W. Indiantown Rd.
Jupitar, Florida 33458
Ph-561-744-7373
Fax-561-743-1192

2240 Palm Beach Lakes Blvd. Suite #225
West Palm Beach, Fl 33409
Ph-561-684-8774
Fax-561-721-2564

Medicare/Medicaid Waiver Form

ATTENTION: If you have had any treatment by a Home Health Agency or if you reside in a Nursing Home, Medicare may not reimburse Physical therapy Institute and Aquatic Rehab. for your physical therapy treatment.

Prior to receiving any out-patient physical therapy treatment from Physical Therapy Institute and Rehab. and it is your responsibility to make sure Medicare/Medicaid is aware that you have discontinued any prior Home Health services.

Please sign and date below acknowledging that you, the patient, understand that you will be billed for any and all services that are not covered by Medicare/Medicaid due to Home Health or Nursing Home treatment.

Thank You.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

Clinic Representative: JOY Fulton

Clinic Location: _____ _____

WRITTEN DISCLOSURE FORM (F.S. 456.052)

Dr. John Papa, DC has a financial interest in the following entities:

ROYAL PALM BEACH REHAB, CORP. DBA FLORIDA ORTHOCARE
Offices in Miami, Broward, Palm Beach, Martin (www.florthocare.com)
CERTIFIED SPINE AND PAIN CARE, LLC
Offices in Miami, Broward, Palm Beach (www.certifiedspineandpain.com)

AS THE PATIENT YOU HAVE A RIGHT TO OBTAIN THE SAME ITEMS/SERVICES AT ONE OF THE ABOVE-LISTED LOCATIONS OR AT A DIFFERENT LOCATION OF YOUR CHOICE. YOU MAY OBTAIN THESE SAME ITEMS/SERVICES AT THE FOLLOWING LOCATIONS WHERE DR. JOHN PAPA, DC, DOES NOT HAVE A FINANCIAL INTEREST:

MIAMI-DADE COUNTY

- Pain Medicine, Baptist Health, 13101 S. Dixie Highway, Suite 400, Miami, FL 33156
- Advanced Institute for Pain Management, University of Miami, 1120 NW 14 Street, 9th Floor, Suite 101, Miami, FL

BROWARD COUNTY

- American Pain Experts, 1164 E. Oakland Park Blvd., Suite 201, Oakland Park FL, 33334
- Broward Health Pain Management, 2100 E Sample Road, Suite 203, Lighthouse Point, FL 33064

PALM BEACH COUNTY

- National Pain Institute, 5365 West Atlantic Avenue, Suite 504, Delray Beach, FL 33484
- Resolute Pain Solutions, 4510 Donald Ross Road, Palm Beach Gardens, FL 33418

MARTIN COUNTY

- Pain Management, Martin Health, 509 Riverside Dr., Suite 203, Stuart, FL 34994
- Resolute Pain Solutions, 2100 SE Ocean Boulevard, Suite 100, Stuart, FL 34996

Patient Signature _____ Date _____

The 2018 Florida Statutes

Title XXXII
REGULATION OF PROFESSIONS AND OCCUPATIONS

Chapter 456
HEALTH PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS

View Entire Chapter

456.052 Disclosure of financial interest by production.—

(1) A health care provider shall not refer a patient to an entity in which such provider is an investor unless, prior to the referral, the provider furnishes the patient with a written disclosure form, informing the patient of:

(a) The existence of the investment interest.

(b) The name and address of each applicable entity in which the referring health care provider is an investor.

(c) The patient's right to obtain the items or services for which the patient has been referred at the location or from the provider or supplier of the patient's choice, including the entity in which the referring provider is an investor.

(d) The names and addresses of at least two alternative sources of such items or services available to the patient.

(2) The physician or health care provider shall post a copy of the disclosure forms in a conspicuous public place in his or her office.

(3) A violation of this section shall constitute a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. In addition to any other penalties or remedies provided, a violation of this section shall be grounds for disciplinary action by the respective board.

History.—s. 1, ch. 86-31; s. 84, ch. 91-224; s. 13, ch. 92-178; s. 92, ch. 97-261; s. 76, ch. 2000-160.

Note.—Former s. 455.25; s. 455.701.

APTA
American Physical Therapy Association

Patient Name:_____

OPTIMAL INSTRUMENT
Demographic Information

Date:_____

1. Date of Birth _____
   mm / dd / yyyy

2. Sex
   1) ____Male
   2) ____Female

3. Race
   1) ____Aleut/Eskimo
   2) ____American Indian
   3) ____Asian/Pacific Islander
   4) ____Black
   5) ____White
   6) ____Other

4. Ethnicity
   1) ____Hispanic or Latino
   2) ____Not Hispanic or Latino

5. Insurance (Please check all that apply)
   1) ____Workers' compensation
   2) ____Self-pay
   3) ____HMO/PPO/private insurance
   4) ____Medicare
   5) ____Medicaid
   6) ____Auto
   7) ____Other

6. Education (Please check one)
   1) ____Less than high school
   2) ____Some high school
   3) ____High school graduate
   4) ____Attended or graduated from technical school
   5) ____Attended college, did not graduate
   6) ____College graduate
   7) ____Completed graduate school/advanced degree

7. Please check the combined annual income of everyone in your house:
   1) ____Less than $10,000
   2) ____$10,000–$14,999
   3) ____$15,000–$24,999
   4) ____$25,000–$34,999
   5) ____$35,000–$49,999
   6) ____$50,000–$74,999
   7) ____$75,000–$99,999
   8) ____$100,000–$149,999
   9) ____$150,000 or more

8. Employment/Work (Check all that apply)
   1) ____Working full-time outside of home
   2) ____Working part-time outside of home
   3) ____Working full-time from home
   4) ____Working part-time from home
   5) ____Working with modification in job because of current illness/injury
   6) ____Not working because of current illness/injury
   7) ____Homemaker
   8) ____Student
   9) ____Retired
   10) ____Unemployed

   Occupation:_____

9. Do you use a: (Check all that apply)
   1) ____Cane?
   2) ____Walker, rolling walker, or rollator?
   3) ____Manual wheelchair?
   4) ____Motorized wheelchair?
   5) ____Other:_____

10. With whom do you live? (Check all that apply)
   1) ____Alone
   2) ____Spouse/significant other
   3) ____Child/children
   4) ____Other relative(s)
   5) ____Group setting
   6) ____Personal care attendant
   7) ____Other:_____

11. Where do you live?
   1) ____Private home
   2) ____Private apartment
   3) ____Rented room
   4) ____Board and care/assisted living/group home
   5) ____Homeless (with or without shelter)
   6) ____Long-term care facility (nursing home)
   7) ____Hospice
   8) ____Other

Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther.* 2005;85:515–530.

Scoring of OPTIMAL

The Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL) is an instrument that measures difficulty and self-confidence in performing 21 movements that a patient/client needs to accomplish in order to do various functional activities.

Scoring is relatively simple, and it can be done in three different ways. The most expedient way to calculate a **total score** is to sum the responses (marked on a 1 to 5 scale) across all 21 items on difficulty and on self-confidence upon both the patient's/client's admission (baseline) and discharge from physical therapy (final). Then subtract the final sum from the baseline sum. The higher the change score, the more the patient has improved. If a particular item on the OPTIMAL is marked as "Not Applicable," then this item should be dropped completely from the overall scoring. For example, suppose that one item is marked "Not Applicable." The best possible score on "Difficulty" or "Self-confidence" for this patient would be "20" (1 x 20 items) and the worst possible score would be "100" (5 x 20 items). Do not add "9" to the score ("9" is an arbitrary coding convention to distinguish the item from missing data if you are entering information into a database.)

Psychometric testing of the instrument also determined that the 21 items form three subscales: upper extremity, lower extremity; and trunk mobility. For some patients, it may be helpful to analyze changes in difficulty or self-confidence in performing specific movements by calculating a **subscale score** as well as a total score.

Finally, the instrument includes a question that asks the patient/client, "From the above list [referring to the 21 items], choose the 3 activities you would most like to be able to do without any difficulty," which may also provide clinically meaningful information. The therapist can calculate a specific **item score** to appraise the changes between admission and discharge scores on these three items. This scoring method allows the therapist to determine the outcome of treatment on the ability to perform the movements that were most important to the patient/client. This method particularly aids in the clinical decision-making process.

For more information about the psychometric properties of OPTIMAL, as well as discussing its scoring, please contact the Division of Practice and Research at the American Physical Therapy Association (APTA).

[updated 02/23/07]

OPTIMAL INSTRUMENT

Patient Name:_____

Date:_____

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about *all* of the activities you would like to do, please mark an "X" at the point on the line that best describes your *overall* level of difficulty with these activities today.

I have *extreme difficulty* doing any of the activities that I would like to do.

I have *no difficulty* doing any of the activities that I would like to do.

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1. 12 2. 8 3. 13*)

1.____ 2.____ 3.____

Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther.* 2005;85:515-530.